

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3147 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03141

Reg. Dist. No.

| | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Oakland</u> | | | c. LENGTH OF STAY IN lb <u>12 yrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Oakland</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Paul</u> Last <u>Dill</u> | | | | 4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>1959</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>August 2, 1916</u> | |
| 9. AGE (In years last birthday) <u>42</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Hours Min. | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Contracting</u> | | 11. BIRTHPLACE (State or foreign country) <u>Iowa</u> | |
| 13. FATHER'S NAME <u>Robert Dill</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Emma Becker</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>10/12/48</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>213-12-7423</u> | | 17. INFORMANT <u>Dessie (NAIR) Dill</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, lobar, bilateral</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aortic stenosis with left ventricular hypertrophy</u> DUE TO (c) <u>secondary to old rheumatic heart disease</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>411X</u> days <u>Years</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour <u>19</u> a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u> | | | | DATE SIGNED <u>5-23-59</u> | | | |
| EXAMINER'S NAME (Type) <u>James H. Feaster, Jr., M. D.</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>5/25/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Oakland</u> <u>Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Gerald N. Minnich</u> | | | | ADDRESS <u>Oakland Md.</u> | | 24a. REC'D BY REGISTRAR <u>DATE MAR 31 '59</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u> | | | | | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | |
|------------------------|--|-------------------------------|--|---------------------------|--|---------------------------|--|-----------------------|--|
| Name of Deceased | | Age | | Sex | | Race | | Date of Death | |
| Place of Birth | | Usual Residence | | Cause of Death | | Manner of Death | | Signature of Examiner | |
| Occupation | | Education | | Medical History | | Physical Examination | | Autopsy | |
| Social History | | Family History | | Mental Examination | | Toxicology | | Other | |
| Signature of Physician | | Signature of Medical Examiner | | Signature of Coroner | | Signature of Juror | | Signature of Witness | |
| Signature of Deceased | | Signature of Next of Kin | | Signature of Funeral Home | | Signature of Burial Place | | Signature of Cemetery | |

FILED IN VOLUME 1000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3148

CERTIFICATE OF DEATH

03142

Reg. Dist. No.

| | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u> | | | | c. LENGTH OF STAY IN 1b <u>3 1/2</u> days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garrett County Memorial Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>John</u> Last <u>Edwards, Sr.</u> | | | | 4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>19 59</u> | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>April 13, 1882</u> | |
| 9. AGE (In years last birthday) <u>76</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>coal miner</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>coal mining (soft)</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>Samuel Edwards</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Ann Campbell</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>217-01-1306</u> | | | |
| 17. INFORMANT <u>Mrs. Carrie Edwards, Box 337, Mt. Lake Park, Md.</u> | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia Terminal</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) <u> </u> | | | | 20g. (County) <u> </u> | | 20h. (State) <u> </u> | |
| 21. I certify that I attended the deceased from <u>10-15</u> , 19 <u>56</u> , to <u>March 29, 1959</u> , that I last saw the deceased alive on <u>29 Mar</u> , 19 <u>59</u> , and that death occurred at <u>11:10 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>A.E. Mance</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Oakland, Md.</u> | | | |
| DATE SIGNED <u>20 Mar 59</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>Dr. Andrew E. Mance, M.D.</u> | | | | <u>Oakland, Maryland</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>4/1/1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Elk Garden, W. Va.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H.C. Leighton</u> | | | | ADDRESS <u>Oakland, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>APR 3 '59</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hance</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[illegible]

THE UNIVERSITY OF CHICAGO PRESS

3149

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakland | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Garrett | |
| c. LENGTH OF STAY IN 1b 60 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Oakland, | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5 Mi. So. Oakland, | | d. STREET ADDRESS 5 Mi. So. Oakland, | |
| 3. NAME OF DECEASED (Type or print) First Alice Middle Custer Last Friend | | 4. DATE OF DEATH Month March Day 1 Year 1959 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 5, 1872 |
| 9. AGE (In years last birthday) 86 yrs. | | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Emanuel Custer | | 14. MOTHER'S MAIDEN NAME Virginia DeWitt | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. --- | |
| 17. INFORMANT Otha Friend | | Address Mt. Lake Park, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHIECTASIS- | | | INTERVAL BETWEEN ONSET AND DEATH 5 weeks |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from JAN 19 , 19 59 to Jan 1 , 19 59 , that I last saw the deceased alive on Jan 28 , 19 59 , and that death occurred at 8:00 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE E. J. Baumgartner | | ADDRESS (Street, city or town, state) 25 ALDER ST | |
| PHYSICIAN'S NAME (Type) E. J. BAUMGARTNER | | DATE SIGNED 3/3/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 3/4/1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Pleasant Valley Cemetery, near Oakland, Md. | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton | | ADDRESS Oakland, Md. | |
| 24a. REC'D BY REGISTRAR MAR 5 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur E. Kline | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG240 3-26-59 et

CERTIFICATE OF DEATH

3150 Items 8.9 FilmG240 3-31-59 et

Reg. Dist. No.

03144

| | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u> ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u> | | c. LENGTH OF STAY IN 1b <u>6 mos.</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> | | <u>0102-2</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Evans Nursing Home</u> | | d. STREET ADDRESS <u>313 Footer Place</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Grimes</u> Last <u>Grimes</u> | | 4. DATE OF DEATH Month <u>3</u> Day <u>18</u> Year <u>1959</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Mar. 23, 1868</u> |
| 9. AGE (In years, last birthday) <u>90</u> yrs. | | IF UNDER 1 YEAR Months <u>1</u> Days <u>18</u> Hours <u>59</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Rail Road</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Keyser, W. Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Andrew J. Grimes</u> | | 14. MOTHER'S MAIDEN NAME <u>Harriett Perry</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>A-110-662</u> | |
| 17. INFORMANT <u>Woodrow Grimes, Cumberland Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.1</u> DUE TO <u>My Gangrene, Left foot</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>?</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 and 3</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Sept 11, 1958</u> to <u>March 18, 1959</u> , that I lost saw the deceased alive on <u>March 18, 1959</u> , and that death occurred at <u>5:07 PM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>E. L. Baumgartner</u> M.D. | | ADDRESS (Street, city or town, state) <u>3522 DEN ST OAKLAND</u> | |
| DATE SIGNED <u>3/10/59</u> | | | |
| PHYSICIAN'S NAME (Type) <u>E. L. BAUMGARTNER</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>3/24/1959</u> | |
| 22c. NAME OF CEMETERY OR CRMATORY <u>Fort Ashby Cem</u> | | 22d. LOCATION (City, town, or county) (State) <u>Fort Ashby, W. Va</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Right</u> | | ADDRESS | |
| 24a. REC'D BY REGISTRAR DATE <u>MAR 23 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

CERTIFICATE OF DEATH

| | | | |
|----------------------------------------------------------|--|--------------------------------------------------------|--|
| <p>1. Name of deceased: <i>John J. Smith</i></p> | | <p>2. Sex: <i>Male</i></p> | |
| <p>3. Age: <i>45</i></p> | | <p>4. Date of death: <i>Jan 15, 1910</i></p> | |
| <p>5. Place of death: <i>Home</i></p> | | <p>6. Cause of death: <i>Heart Disease</i></p> | |
| <p>7. Signature of physician: <i>Dr. J. H. Smith</i></p> | | <p>8. Signature of registrar: <i>John J. Smith</i></p> | |
| <p>9. Date of registration: <i>Jan 15, 1910</i></p> | | <p>10. Place of registration: <i>Boston</i></p> | |
| <p>11. Name of informant: <i>John J. Smith</i></p> | | <p>12. Address of informant: <i>123 Main St.</i></p> | |
| <p>13. Name of informant: <i>John J. Smith</i></p> | | <p>14. Address of informant: <i>123 Main St.</i></p> | |
| <p>15. Name of informant: <i>John J. Smith</i></p> | | <p>16. Address of informant: <i>123 Main St.</i></p> | |
| <p>17. Name of informant: <i>John J. Smith</i></p> | | <p>18. Address of informant: <i>123 Main St.</i></p> | |
| <p>19. Name of informant: <i>John J. Smith</i></p> | | <p>20. Address of informant: <i>123 Main St.</i></p> | |
| <p>21. Name of informant: <i>John J. Smith</i></p> | | <p>22. Address of informant: <i>123 Main St.</i></p> | |
| <p>23. Name of informant: <i>John J. Smith</i></p> | | <p>24. Address of informant: <i>123 Main St.</i></p> | |
| <p>25. Name of informant: <i>John J. Smith</i></p> | | <p>26. Address of informant: <i>123 Main St.</i></p> | |
| <p>27. Name of informant: <i>John J. Smith</i></p> | | <p>28. Address of informant: <i>123 Main St.</i></p> | |
| <p>29. Name of informant: <i>John J. Smith</i></p> | | <p>30. Address of informant: <i>123 Main St.</i></p> | |
| <p>31. Name of informant: <i>John J. Smith</i></p> | | <p>32. Address of informant: <i>123 Main St.</i></p> | |
| <p>33. Name of informant: <i>John J. Smith</i></p> | | <p>34. Address of informant: <i>123 Main St.</i></p> | |
| <p>35. Name of informant: <i>John J. Smith</i></p> | | <p>36. Address of informant: <i>123 Main St.</i></p> | |
| <p>37. Name of informant: <i>John J. Smith</i></p> | | <p>38. Address of informant: <i>123 Main St.</i></p> | |
| <p>39. Name of informant: <i>John J. Smith</i></p> | | <p>40. Address of informant: <i>123 Main St.</i></p> | |
| <p>41. Name of informant: <i>John J. Smith</i></p> | | <p>42. Address of informant: <i>123 Main St.</i></p> | |
| <p>43. Name of informant: <i>John J. Smith</i></p> | | <p>44. Address of informant: <i>123 Main St.</i></p> | |
| <p>45. Name of informant: <i>John J. Smith</i></p> | | <p>46. Address of informant: <i>123 Main St.</i></p> | |
| <p>47. Name of informant: <i>John J. Smith</i></p> | | <p>48. Address of informant: <i>123 Main St.</i></p> | |
| <p>49. Name of informant: <i>John J. Smith</i></p> | | <p>50. Address of informant: <i>123 Main St.</i></p> | |
| <p>51. Name of informant: <i>John J. Smith</i></p> | | <p>52. Address of informant: <i>123 Main St.</i></p> | |
| <p>53. Name of informant: <i>John J. Smith</i></p> | | <p>54. Address of informant: <i>123 Main St.</i></p> | |
| <p>55. Name of informant: <i>John J. Smith</i></p> | | <p>56. Address of informant: <i>123 Main St.</i></p> | |
| <p>57. Name of informant: <i>John J. Smith</i></p> | | <p>58. Address of informant: <i>123 Main St.</i></p> | |
| <p>59. Name of informant: <i>John J. Smith</i></p> | | <p>60. Address of informant: <i>123 Main St.</i></p> | |
| <p>61. Name of informant: <i>John J. Smith</i></p> | | <p>62. Address of informant: <i>123 Main St.</i></p> | |
| <p>63. Name of informant: <i>John J. Smith</i></p> | | <p>64. Address of informant: <i>123 Main St.</i></p> | |
| <p>65. Name of informant: <i>John J. Smith</i></p> | | <p>66. Address of informant: <i>123 Main St.</i></p> | |
| <p>67. Name of informant: <i>John J. Smith</i></p> | | <p>68. Address of informant: <i>123 Main St.</i></p> | |
| <p>69. Name of informant: <i>John J. Smith</i></p> | | <p>70. Address of informant: <i>123 Main St.</i></p> | |
| <p>71. Name of informant: <i>John J. Smith</i></p> | | <p>72. Address of informant: <i>123 Main St.</i></p> | |
| <p>73. Name of informant: <i>John J. Smith</i></p> | | <p>74. Address of informant: <i>123 Main St.</i></p> | |
| <p>75. Name of informant: <i>John J. Smith</i></p> | | <p>76. Address of informant: <i>123 Main St.</i></p> | |
| <p>77. Name of informant: <i>John J. Smith</i></p> | | <p>78. Address of informant: <i>123 Main St.</i></p> | |
| <p>79. Name of informant: <i>John J. Smith</i></p> | | <p>80. Address of informant: <i>123 Main St.</i></p> | |
| <p>81. Name of informant: <i>John J. Smith</i></p> | | <p>82. Address of informant: <i>123 Main St.</i></p> | |
| <p>83. Name of informant: <i>John J. Smith</i></p> | | <p>84. Address of informant: <i>123 Main St.</i></p> | |
| <p>85. Name of informant: <i>John J. Smith</i></p> | | <p>86. Address of informant: <i>123 Main St.</i></p> | |
| <p>87. Name of informant: <i>John J. Smith</i></p> | | <p>88. Address of informant: <i>123 Main St.</i></p> | |
| <p>89. Name of informant: <i>John J. Smith</i></p> | | <p>90. Address of informant: <i>123 Main St.</i></p> | |
| <p>91. Name of informant: <i>John J. Smith</i></p> | | <p>92. Address of informant: <i>123 Main St.</i></p> | |
| <p>93. Name of informant: <i>John J. Smith</i></p> | | <p>94. Address of informant: <i>123 Main St.</i></p> | |
| <p>95. Name of informant: <i>John J. Smith</i></p> | | <p>96. Address of informant: <i>123 Main St.</i></p> | |
| <p>97. Name of informant: <i>John J. Smith</i></p> | | <p>98. Address of informant: <i>123 Main St.</i></p> | |
| <p>99. Name of informant: <i>John J. Smith</i></p> | | <p>100. Address of informant: <i>123 Main St.</i></p> | |

Handwritten notes and signatures on the right margin.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03145

Reg. Dist. No.

3151

| | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Oakland, Garrett</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>W. Va.</u> b. COUNTY <u>Grant</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland,</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Emoryville</u> <u>851-3</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garrett County Memorial Hospital</u> | | d. STREET ADDRESS <u>Emoryville</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>William</u> Last <u>Hipp</u> | | 4. DATE OF DEATH Month <u>3</u> Day <u>25</u> Year <u>1959</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4/3/1880</u> |
| 9. AGE (In years last birthday) <u>78</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Coal Miner</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Soft Coal mines</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>America (Iowa)</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>America U.S.A.</u> | |
| 13. FATHER'S NAME <u>Hipp, Frank</u> | | 14. MOTHER'S MAIDEN NAME <u>Bosley, Cindy</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>212-12-8201</u> | |
| 17. INFORMANT <u>Everson Hipp</u> | | Address <u>Emoryville, W. Va.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Arterio-sclerotic Cardio -</u> DUE TO <u>vascular disease</u> (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u> <u>YEARS</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>59</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>June</u> , 19 <u>58</u> , to <u>3 24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-27</u> , 19 <u>59</u> , and that death occurred at <u>1:55 A.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u> M.D. <u>58 21 St. Oakland Md</u> | | DATE SIGNED <u>3 25 59</u> | |
| PHYSICIAN'S NAME (Type) <u>Dr. J. H. Feaster, Jr.</u> | | <u>Oakland, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>3/27/1959</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Elk Garden, W. Va.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H. C. Leighton</u> ADDRESS <u>Oakland, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>MAR 30 '59</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huang</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 19

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 19

Form with multiple lines for text entry, including fields for name, date, and location.

CERTIFICATE OF DEATH

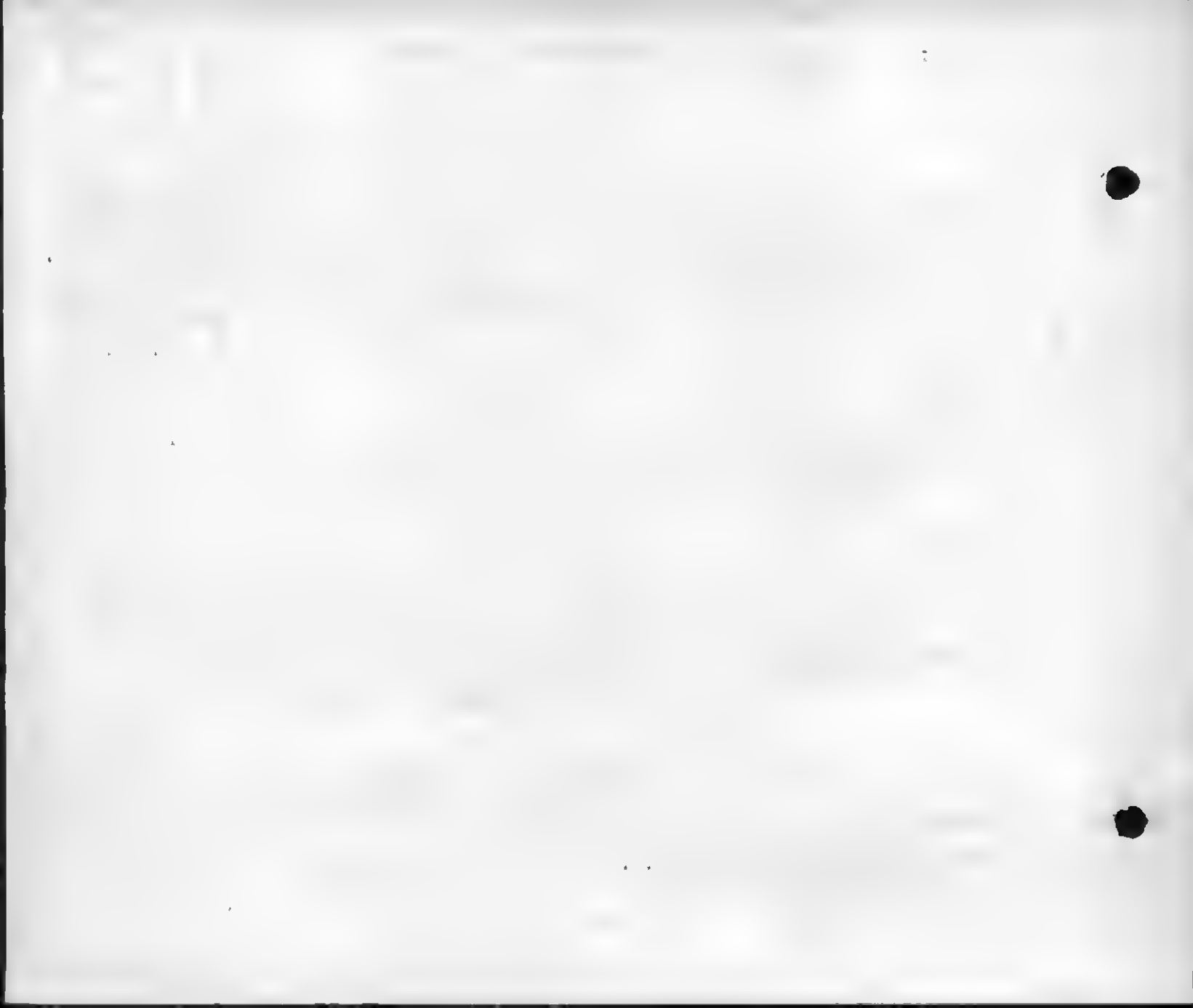
Reg. Dist. No.

3152

| | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE MARYLAND c. COUNTY GARRETT | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND | | c. LENGTH OF STAY IN 1b 1 day | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL | | e. STREET ADDRESS WATER STREET | |
| 3. NAME OF DECEASED (Type or print) First Middle Last JAMES Andrew KERINS | | 4. DATE OF DEATH Month Day Year MARCH 30 1959 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 21, 1883 |
| 9. AGE (In years last birthday) 75 yrs | | 10. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC | | 10b. KIND OF BUSINESS OR INDUSTRY AUTO | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JAMES KERINS | | 14. MOTHER'S MAIDEN NAME MARGARET Melvin | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 212-24-1267 | |
| 17. INFORMANT George Kerins | | Address Oakland, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 DUE TO Broncho pneumonia, Bilat. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 days 5 years | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 9, 1958, to March 30, 1959, that I last saw the deceased alive on 30 Mar, 1959, and that death occurred at 5:05 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Andrew E. Mance M.D. | | ADDRESS (Street, city or town, state) Oakland Md | |
| PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M.D. | | DATE SIGNED 31 Mar 59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 4/2/1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Catholic Cemetery | | 22d. LOCATION (City, town, or county) (State) Oakland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE H. E. Lenthorn | | ADDRESS Oakland, Md. | |
| 24a. REC'D BY REGISTRAR DATE APR 3 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur E. Hance | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03147

Reg. Dist. No.

| | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------|--|
| 3153 | | | | Reg. Dist. No. | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Garrett.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Oakland</u> | | c. LENGTH OF STAY IN TB <u>6 Months</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Lake Park.</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home of Lewis VanSickle</u> | | | | d. STREET ADDRESS <u>Loch Lynn</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>John Bance King</u> | | | | 4. DATE OF DEATH Month Day Year <u>March 20, 1959</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>June 2, 1880</u> | |
| | | | | 9. AGE (In years last birthday) <u>78</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Coal Miner</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Soft Coal Mines</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Arch King</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Frances Biggs</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>220-07-6716</u> | | 17. INFORMANT <u>John R. King</u> | | Address <u>Mt. Lake Park, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>4-0-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u> | | | | DATE SIGNED CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>James H. Feaster, Jr.</u> | | | | 3-20-59 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>3/22/1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Deer Park Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Deer Park, Maryland.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Leighton</u> | | | | ADDRESS <u>Oakland, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>3-23-59</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>S. T. Smith</u> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03148

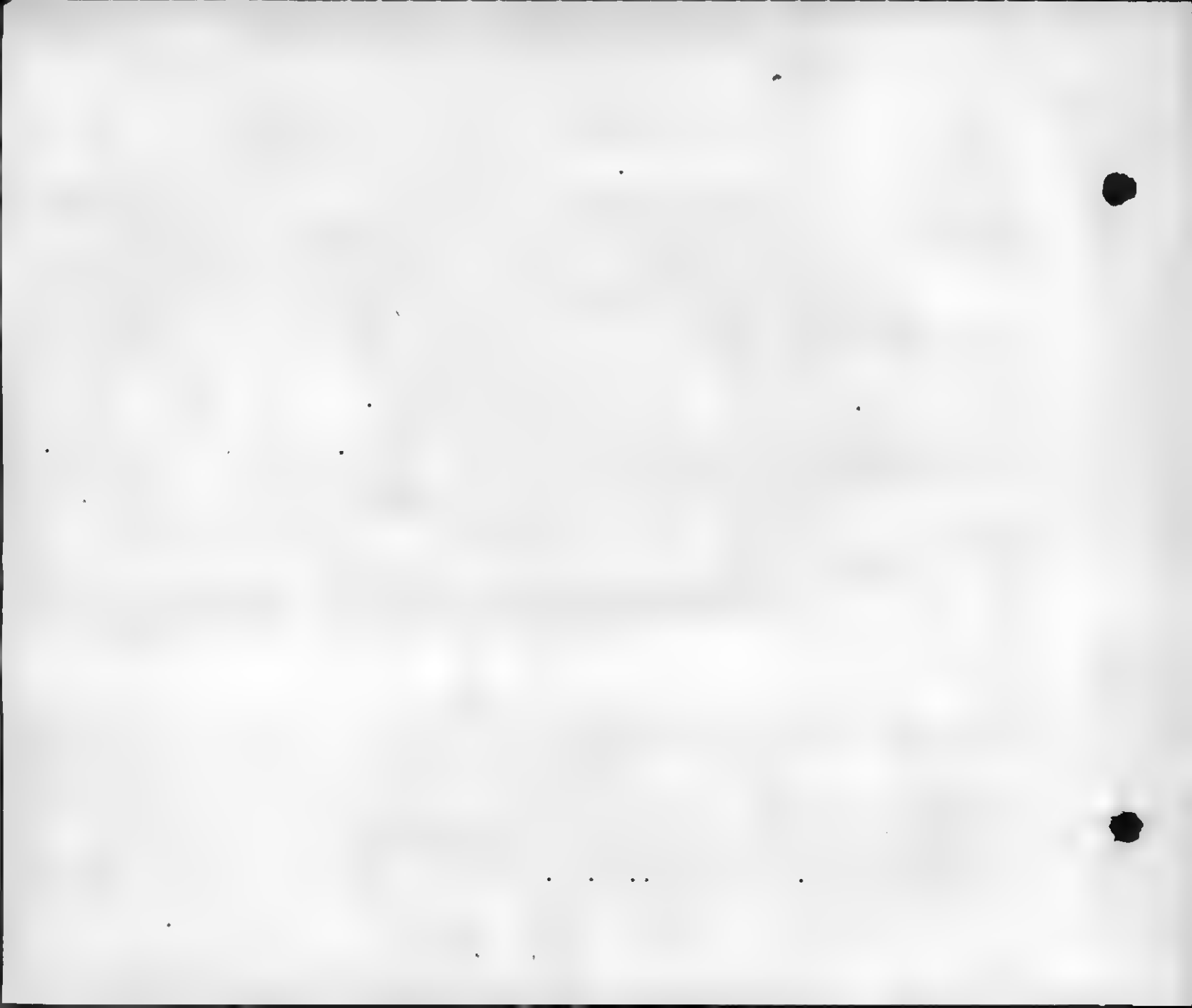
Reg. Dist. No.

3154

| | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u> | | c. LENGTH OF STAY IN 1b <u>1 Hr. 50 Min</u> <u>Rural</u> <u>Oakland</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garrett County Memorial Hospital</u> | | | | d. STREET ADDRESS <u>Route # 2</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Darnie</u> Middle <u>Ray</u> Last <u>Miller</u> | | | | 4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>19 59</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>January 27, 54</u> | | | |
| 9. AGE (In years last birthday) <u>5</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Oakland, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>America</u> | | | | | |
| 13. FATHER'S NAME <u>Joni J. Miller</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Fannie J. Miller</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>"Father" Joni J. Miller, Oakland, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Spontaneous intracerebral hemorrhage, diffuse</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | | | |
| 20f. (City or town) _____ | | (County) _____ | | (State) _____ | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>James H. Leaster Jr.</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>James H. Leaster Jr. M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DATE SIGNED <u>3-5-59</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>3/7/1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Slabaugh Cemetery</u> | | | |
| 22d. LOCATION (City, town, or county) <u>near Oakland, Md.</u> | | (State) _____ | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H. C. Leighton</u> | | ADDRESS <u>Oakland, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>MAR 11 '59</u> | | | |
| 24b. REGISTRAR'S SIGNATURE <u>Orville S. Kraus</u> | | 24c. REGISTRAR'S SIGNATURE | | | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

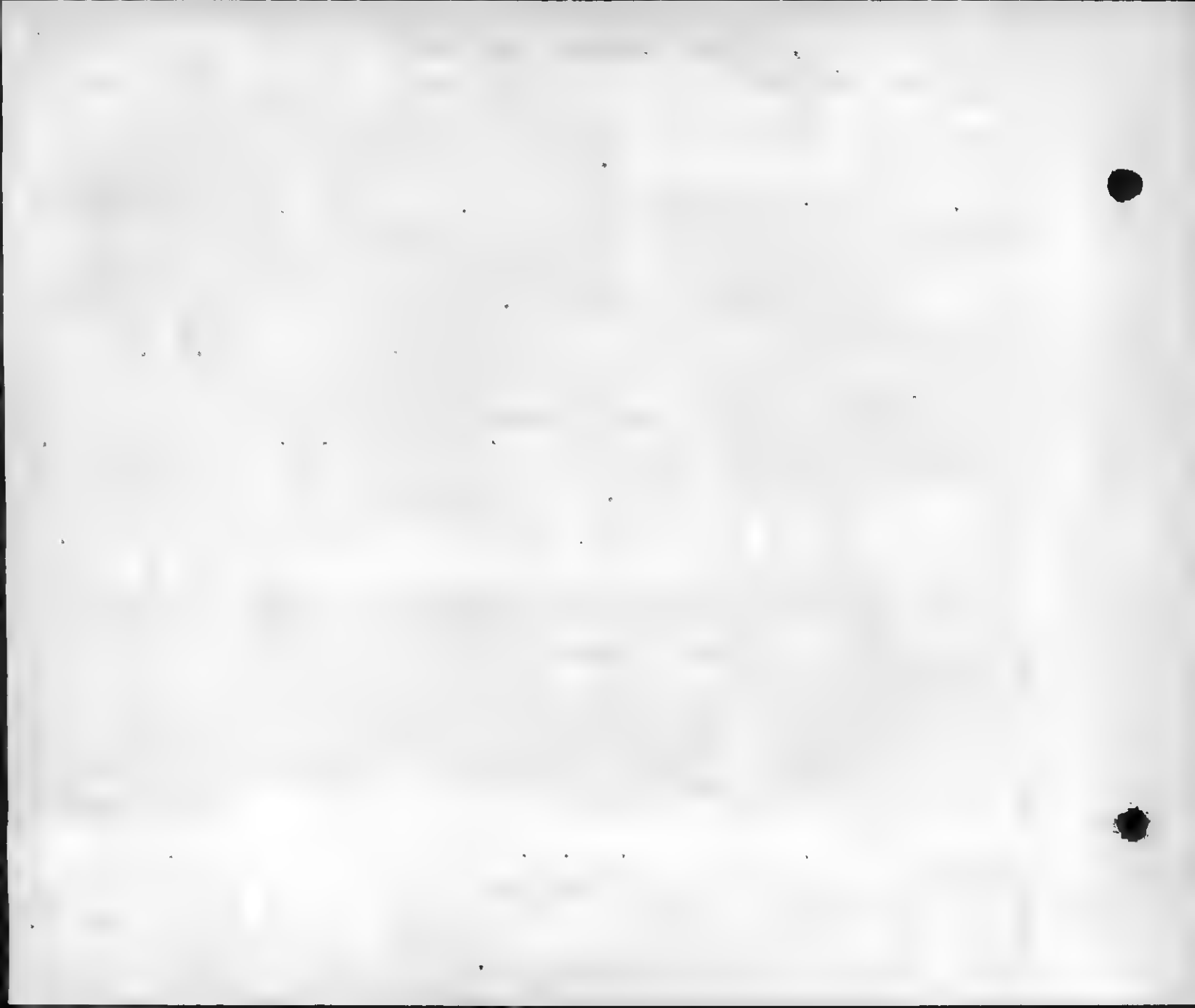
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03149

Reg. Dist. No.

| | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|--------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>Garrett</u> 3153 MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Gorman</u> c. LENGTH OF STAY IN 1b <u>16 Mo.</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Gorman</u> d. STREET ADDRESS <u>2 Mi. West Gorman, Route #50</u> # <u>50</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Joseph</u> Last <u>Moreland</u> | | | | 4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>19 59</u> | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>Nov. 3, 1957</u> | | 9. AGE (In years last birthday) <u>1</u> yrs IF UNDER 1 YEAR: Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>Roy G. Moreland</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Selma Jordan</u> | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>---</u> | | 17. INFORMANT Address <u>Roy G. Moreland R. D. Gorman, W. Va.</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, right upper lobe</u> <u>493x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Dehydration, marked</u> (c) <u>493x</u> DUE TO (a) stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>24 hrs.</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493x</u> | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>19</u> p. m. | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED <u>3-12-59</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 22b. DATE THEREOF <u>3/14/1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Cemetery</u> | | | 22d. LOCATION (City, town, or county) (State) <u>Route #50, near Gorman, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H. L. Lightfoot</u> | | | | ADDRESS <u>Oakland, Md.</u> | | 24a. REC'D BY REGISTRAR <u>DATE MAR 16 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinas</u> | |

THE DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



3156

CERTIFICATE OF DEATH

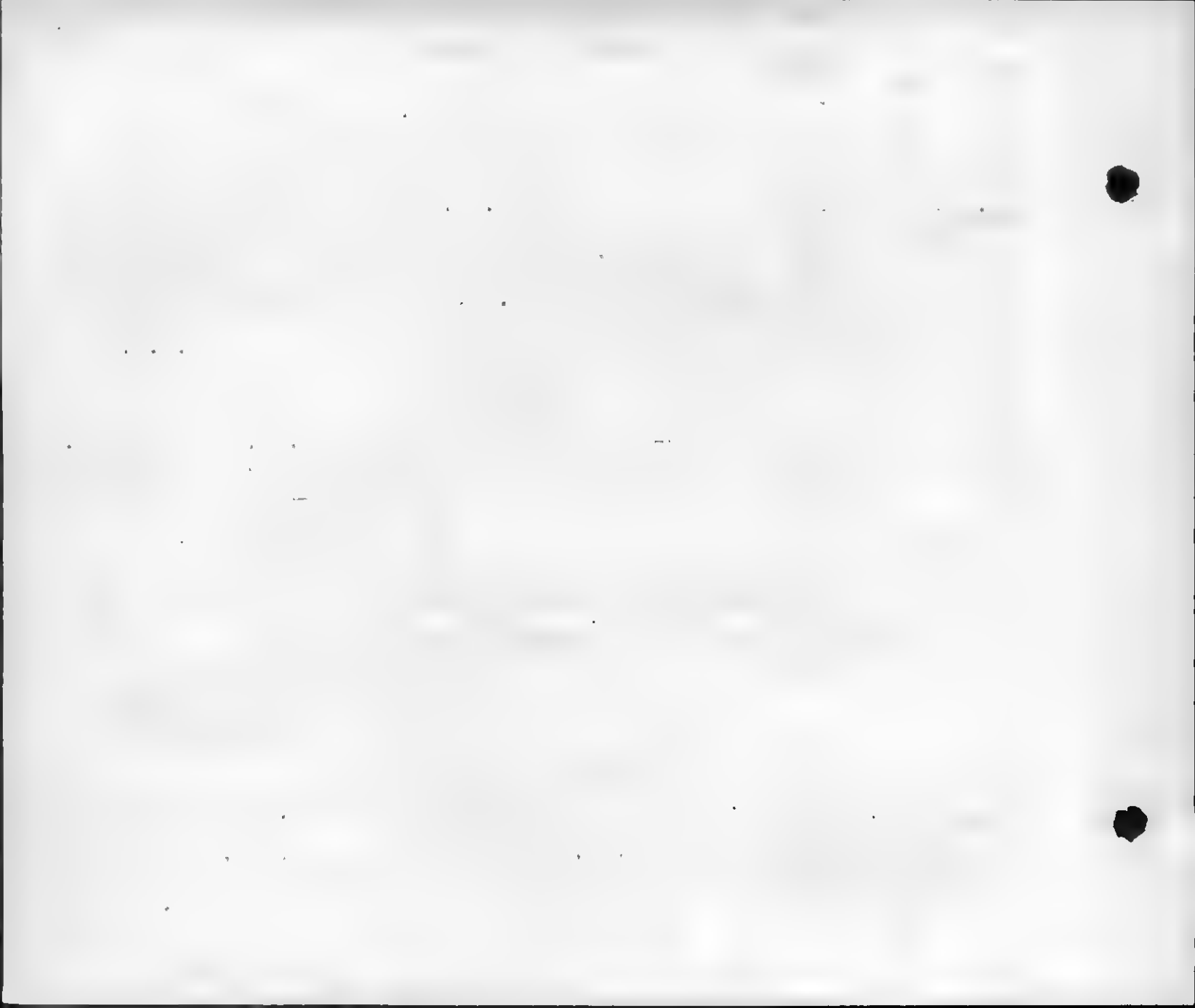
Reg. Dist. No.

| | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Garrett</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Oakland,</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Oakland,</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R. D. #2 Oakland,</u> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>W.</u> Last <u>Nine</u> | | 4. DATE OF DEATH Month <u>March</u> Day <u>6,</u> Year <u>19 59</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 1, 1870</u> |
| 9. AGE (In years last birthday) yrs <u>88</u> | | IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS | |
| 10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Peter Nine</u> | | 14. MOTHER'S MAIDEN NAME <u>Charlotte Whitehair</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO <u>---</u> | |
| 17. INFORMANT <u>Mrs. Charles Nine</u> | | Address <u>R. D. Oakland, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Arteriosclerosis Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Cardiovascular Disease</u> DUE TO <u>disease</u> (c) <u>disease</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinson's Disease</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>July 1955</u> to <u>March 6, 1959</u> , that I last saw the deceased alive on <u>March 4, 1959</u> , and that death occurred at <u>12:30 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>William Harriman</u> M.D. | | ADDRESS (Street, city or town, state) <u>Terra Alta, W. Va.</u> DATE SIGNED <u>3/7/59</u> | |
| PHYSICIAN'S NAME (Type) <u>William Harriman, M. D.</u> | | <u>Terra Alta, W. Va.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>3/8/1959</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Nine Home Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>near Oakland, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H. C. Reighton</u> | | ADDRESS <u>Oakland, Md.</u> | |
| 24a. REC'D BY REGISTRAR DATE <u>MAR 11 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u> | |

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

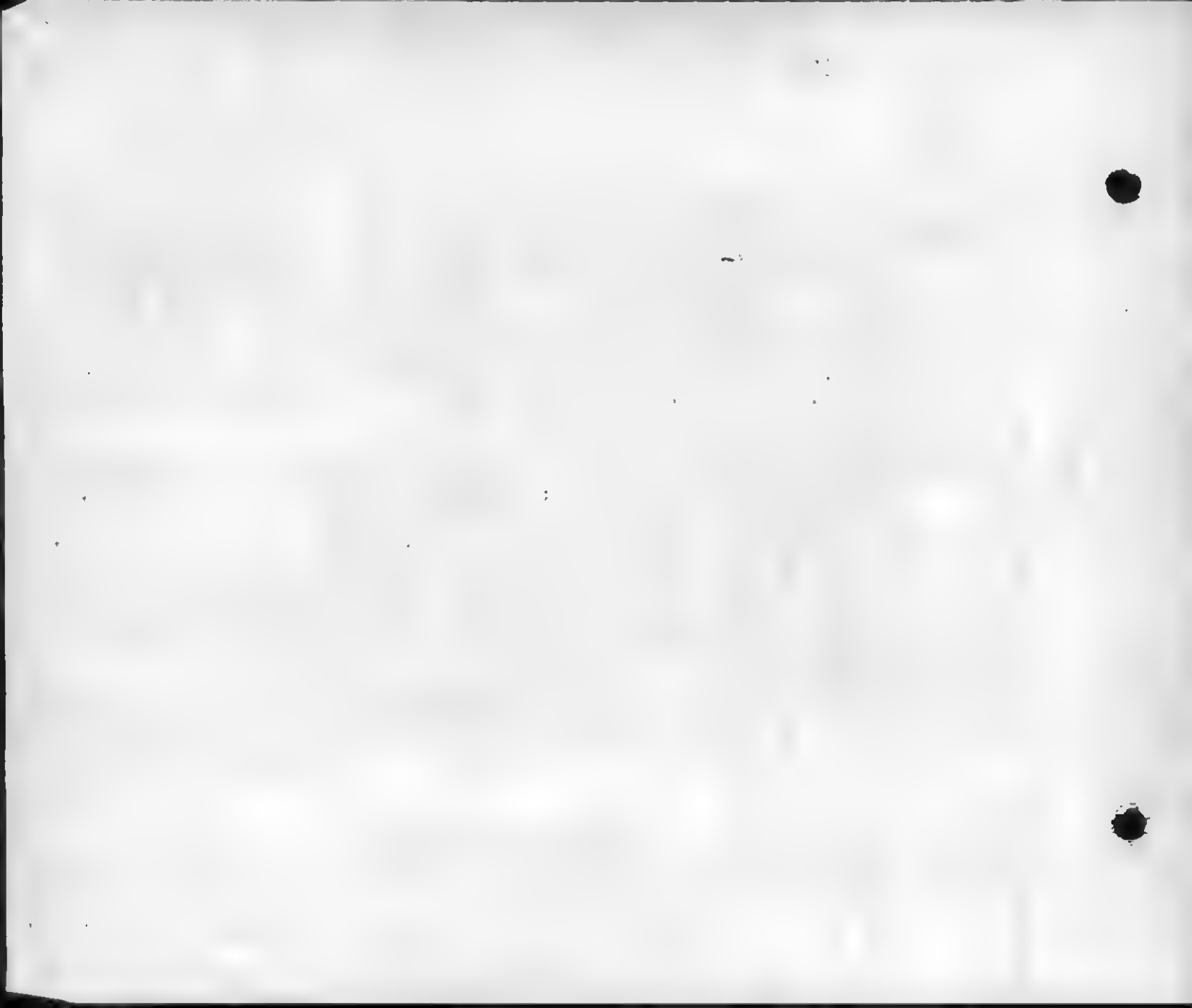
03151

3157

Reg. Dist. No.

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| 1. PLACE OF DEATH a. COUNTY <u>tt</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Arrett</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>tt</u> | | c. LENGTH OF STAY IN 1b <u>tt</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u> <u>tt</u> <u>ville, Md.</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>tt</u> First <u>tt</u> Middle <u>tt</u> Last <u>tt</u> | | | | 4. DATE OF DEATH <u>tt</u> <u>tt</u> <u>tt</u> | | | |
| 5. SEX <u>tt</u> | | 6. COLOR OR RACE <u>tt</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>tt</u> <u>tt</u> <u>tt</u> | |
| 9. AGE (in years last birthday) <u>tt</u> yrs. | | 10. IF UNDER 1 YEAR Mpnths <u>tt</u> Days <u>tt</u> | | 11. IF UNDER 24 HRS. Hours <u>tt</u> Min. <u>tt</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Grantville elem.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Grantville, Md.</u> | |
| 13. FATHER'S NAME <u>tt</u> | | | | 14. MOTHER'S MAIDEN NAME <u>1704 W. Lombard St. Baltimore 23, Md.</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT Address <u>tt</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ASPHYXIATION ; PULMONARY EDEMA</u> DUE TO (b) <u>ACUTE TRACHEOBRONCHITIS, MILD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Also: LARYNGEAL EDEMA, MARKED</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 Hr.</u> <u>12 Hrs.</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HISTORY OF ASTHMA</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour <u>tt</u> a. m. <u>tt</u> p. m. <u>tt</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>James H. Fenster Jr.</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>James H. Fenster Jr.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DATE SIGNED <u>3-7-59</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF <u>3/10/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Grantville</u> | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Con J. Shuman</u> | | | | ADDRESS <u>tt</u> | | 24a. REC'D BY REGISTRAR DATE <u>MAR 12 '59</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u> | | | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



CERTIFICATE OF DEATH

Reg. Dist. No.

3158

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| 1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Deer Park c. LENGTH OF STAY IN lb 10 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1 mile west Deer Park | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Deer Park d. STREET ADDRESS 1 Mile West Deer Park e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Bertha Middle Ellen Last Smouse | | 4. DATE OF DEATH Month March Day 8 Year 1959 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 16, 1882 |
| 9. AGE (In years past birthday) 77 yrs. | | IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. | IF UNDER 24 HRS. Hours 1 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | 11. BIRTHPLACE (State or foreign country) Maryland. |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME George Shartzter | |
| 14. MOTHER'S MAIDEN NAME Hester Conneway | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no | |
| 16. SOCIAL SECURITY NO. --- | | 17. INFORMANT Albert Smouse Address R.D. Deer Park, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Occlusion 260x DUE TO Hypertensive C.V.D. with Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes Mellitus (c) Diabetes Mellitus | | | INTERVAL BETWEEN ONSET AND DEATH 10 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 10/31 , 19 57 , to 3/17 , 19 59 , that I last saw the deceased alive on 11/17 , 19 58 , and that death occurred at 5:30 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Andrew S. Mance M.D. | | ADDRESS (Street, city or town, state) Oakland Md. DATE SIGNED March 7 | |
| PHYSICIAN'S NAME (Type) Andrew E. Mance, M. D. | | Oakland, Maryland. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 3/11/1959 | 22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery | 22d. LOCATION (City, town, or county) (State) Oakland, Maryland. |
| 23. FUNERAL DIRECTOR'S SIGNATURE H. C. Reighton ADDRESS Oakland, Md. | | 24a. REC'D BY REGISTRAR DATE MAR 16 '59 | 24b. REGISTRAR'S SIGNATURE Arthur S. Mance |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILLIAM J. DUNN
JANUARY 1941
BALTIMORE, MD.

| | | | |
|------------------------|--|------------------------|--|
| Name of Deceased | | Date of Death | |
| Sex | | Age | |
| Race | | Place of Birth | |
| Usual Residence | | Cause of Death | |
| Occupation | | Manner of Death | |
| Signature of Physician | | Signature of Registrar | |
| Date of Certificate | | Place of Death | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. For burial, cremation, or removal, TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3159

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03153

Reg. Dist. No.

| | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grantsville, Md.</u> | | c. LENGTH OF STAY IN 1b <u>Life</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grantsville, Md.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>VIRGINIA</u> Middle <u>AUGUSTA</u> Last <u>YOUNKIN</u> | | 4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1959</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 27, 1895</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> | 9. AGE (In years last birthday) <u>1/1463</u> yrs. |
| 11. BIRTHPLACE (State or foreign country) <u>Garrett Co., Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Robert Bows r</u> | | 14. MOTHER'S MAIDEN NAME <u>Katherine Guschlag</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u> | | 16. SOCIAL SECURITY NO. <u>---</u> | |
| 17. INFORMANT <u>Mrs Beulah Youner, Grantsville, Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>4-20.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertensive</u> DUE TO (c) <u>years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>James H. Feaster Jr.</u> | | DATE SIGNED <u>3-24-59</u> | |
| EXAMINER'S NAME (Type) <u>JAMES H. FEASTER JR.</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>3/27/59</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Grantsville,</u> | | 22d. LOCATION (City, town, or county) (State) <u>Grantsville, Garrett Co., Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Don Newman</u> | | ADDRESS <u>Grantsville, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>Mar 30 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u> | |

7-12

| | | | | | | | | | |
|-------------------------------|--|----------------------|--|------------------------|--|----------------------|--|-----------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | |
| John Doe | | Male | | 45 | | Jan 1, 1900 | | New York, N.Y. | |
| Cause of Death | | Manner of Death | | Occupation | | Education | | Religion | |
| Heart Disease | | Natural | | Teacher | | High School | | Catholic | |
| Date of Death | | Time of Death | | Place of Death | | Physician | | Hospital | |
| Jan 15, 1945 | | 10:30 AM | | Home | | Dr. Smith | | St. Mary's | |
| Signature of Medical Examiner | | Signature of Coroner | | Signature of Registrar | | Signature of Witness | | Signature of Deceased | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |

RECEIVED
JAN 15 1945
BUREAU OF VITALS